QUESTIONNAIRE FOR FILING PROPOSED RULES AND REGULATIONS WITH THE ARKANSAS LEGISLATIVE COUNCIL AND JOINT INTERIM COMMITTEE

DEPARTMENT/AGENCY Department of Human Services
DIVISION of County Operations
DIVISION DIRECTOR Ruth Whitney, Director
CONTACT PERSON Sandra Miller, Assistant Director, OPPD

ADDRESS P. O. Box 1437, Slot 1220, Little Rock, AR 72203
PHONE NO. 682- 8251 **FAX NO.** 682-1597

INSTRUCTIONS

A. Please make copies of this form for future use.
B. Please answer each question completely using layman terms. You may use additional sheets, if necessary.
C. If you have a method of indexing your rules, please give the proposed citation after "Short Title of this Rule" below.
D. Submit two (2) copies of this questionnaire attached to the front of two (2) copies of your proposed rule and mail or deliver to:

Donna K. Davis
Subcommittee on Administrative Rules and Regulations
Arkansas Legislative Council
Bureau of Legislative Research
Room 315, State Capitol
Little Rock, AR 72201

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1. **What is the short title of this rule?**
MS 28000, Medicaid for the Working Disabled

2. **What is the subject of the proposed rule?**
Incorporating procedural changes that redefine working to mean employment for which income is received and reported to the IRS, and to clarify that individuals with unearned income over the SSI/SPA are not eligible.

3. **Is this rule required to comply with federal statute or regulations? Yes___No**
If yes, please provide the federal regulation and/or statute citation.

4. **Was this rule filed under the emergency provisions of the Administrative Procedure Act?**
Yes__ No X

If yes, what is the effective date of the emergency rule?

When does the emergency rule expire?

Will this emergency rule be promulgated under the regular provisions of the Administrative Procedure Act? Yes__ No

5. **Is this a new rule? Yes___ No__X_**

Does this repeal an existing rule? Yes___ No__X
If yes, please provide a copy of the repealed rule.

Is this an amendment to an existing rule? Yes__X__No___ If yes, please attach a markup showing the changes in the existing rule and a summary of the substantive changes.

6. **What state law grants the authority for this proposed rule? If codified, please give Arkansas Code citation.**

AR Code Annotated 20-76-201 et. Seq and AR Code Annotated 20-15-201 et. Seq.

7. **What is the purpose of this proposed rule? Why is it necessary?**
To better define for which group of people this category of Medicaid is intended.

8. **Will a public hearing be held on this proposed rule?**
Yes__ No_X_ If yes, please give the date, time, and place of the public hearing?

9. **When does the public comment period expire?**
August 30, 2001.

10. **What is the proposed effective date of this proposed rule?**

September 15, 2001

11. **Do you expect this rule to be controversial? Yes**
No_X__ If yes, please explain.

12. **Please give the names of persons, groups, or organizations which you expect to comment on these rules? Please provide their position (for or against) if known.**

None known.

PLEASE ANSWER ALL QUESTIONS COMPLETELY

July 28, 1995

DEPARTMENT Department of Human Services
DIVISION Division of Medical Services
PERSON COMPLETING THIS STATEMENT Teresa Hursey
TELEPHONE NO. 682-1734 **FAX NO.** 682-2263

FINANCIAL IMPACT STATEMENT

To comply with Act 884 of 1995, please complete the following Financial Impact statement and file with the questionnaire and proposed rules.

SHORT TITLE OF THIS RULE: Arkansas Medicaid State Plan Transmittal # 99-025 to implement the Working Disabled Program

1. Does this proposed, amended, or repealed rule or regulation have a financial impact?
Yes X **No**

2. If you believe that the development of a financial impact statement is so speculative as to be cost prohibited, please explain.

Not Applicable

3. If the purpose of this rule or regulation is to implement a federal rule or regulation, please give the incremental cost for implementing the regulation.

2001 Fiscal Year		**2002 Fiscal Year**	
General Revenue	$ 6,043.66	**General Revenue**	$ 196,932.30
Federal Funds	$ 16,356.86	**Federal Funds**	$ 524,356.77
Cash Funds		**Cash Funds**	
Special Revenue		**Special Revenue**	
Other		**Other**	
Savings Total		**Savings Total**	

4. What is the total estimated cost by fiscal year to any party subject to the proposed, amended, or repealed rule or regulation?

2001 Fiscal Year	**2002 Fiscal Year**
None	None

5. What is the total estimated cost by fiscal year to the agency to implement this regulation?

2001 Fiscal Year		**2002 Fiscal Year**	
State	$ 6,043.66	State	$ 196,932.30
Federal	$ 16,356.86	Federal	$ 524,356.77
Total	**$ 22,400.52**	**Total**	**$ 721,289.07***

***** This is the projected cost of Medicaid benefits for the added group of eligibles.

July 28, 1995

NOTICE OF RULE MAKING

Pursuant to Arkansas Code Annotated 20-76-201 et Seq., Arkansas Code Annotated 20-15-201 et Seq., and Act 416 of 1977, Section 7 of Act 280 of 1939, the Balanced Budget Act of 1997, Public Law 105-33, and Act 1197 of 1999, Medicaid policy is being amended to redefine the definition of working and to add a two-step income eligibility determination to the Working Disabled Policy. This will better define the group of potential eligibles for this category. This change in policy is effective July 1, 2001.

Copies of the proposed change may be obtained by writing the Division of County Operations, P.O. Box 1436, Slot 1220, Little Rock, AR 72203, Attention: Office of Program Planning & Development. All comments must be submitted in writing to the address indicated above no later than 30 days from the date of this notice.

If you need this material in a different format, such as large print, contact our Americans with Disabilities Act Coordinator at 682-8920 (voice) or 682-8933 (TDD).

The Arkansas Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act and is operated, managed and delivers services without regard to age, religion, disability, political affiliation, veteran status, age, race, color or national origin.

_____

Ruth Whitney,
Director, Division of County Operations

Date:_____

28000 Medicaid Coverage for the Working Disabled 09-15-01

The "Ticket to Work and Work Incentives Improvement Act of 1999" (TWWIIA), enacted on December 17,1999, provides states with new options for making it possible for people with disabilities to join, or remain in, the workplace without fear of losing their Medicare and Medicaid coverage. Arkansas elected to provide Medicaid coverage in the "Basic Coverage Group" of TWWIIA. Under this group, Medicaid can cover individuals at least 16, but less than 65 years of age, who, except for earned income, would be eligible to receive Supplemental Security Income (SSI). Medicaid for the Working Disabled in Arkansas becomes effective February 1, 2001.

Formerly, a disabled individual with earnings that exceeded the SGA (substantial gainful activity) of $740.00 per month, was not considered disabled for Arkansas Medicaid purposes. Under this new option, SGA is not an eligibility factor; therefore, more persons with disabilities may increase their earnings or return to work and retain or obtain Medicaid coverage.

Individuals who lose SSI and SSI related Medicaid, due to earnings, are potentially eligible for Medicaid under the Working Disabled policy. There is no requirement that an individual must have at one time been an SSI recipient to be eligible for Medicaid under this category. However, if an individual was not an SSI recipient or a recipient of SSA disability, a disability determination must be made by MRT. Although SGA is **not** considered for this determination, the individual's unearned income must be under the SSI/SPA for one person.

28010 Extent of Services 02-01-01

Recipients of Medicaid in the Working Disabled category will be eligible for the full range of Medicaid services. Cost sharing will be assessed at the point of service in the form of co-payments for medical visits and prescription drugs (See MS 28045).

28015 Working Disabled Eligibility Criteria 09-15-01

Individuals eligible for Medicaid under the Working Disabled program must:

1. Be a resident of the state of Arkansas (Re. MS 2200).
2. Be a U.S. citizen or qualified alien (Re. MS 3310#3 & MS 3324).
3. Be at least 16 years of age but under age 65.
4. Furnish a Social Security Number, or apply for one (Re. MS 1358).
5. Be working (MS 28020).
6. Be disabled according to the SSI definition of disability except for SGA (MS 28025).
7. Have net personal income less than 250% of the poverty level for his/her family size (MS 28030), with unearned income below the SSI/SPA for one person.

8. Have countable resources equal to or less than twice the medically needy resource limit for his/her family size. Only the resources of the individual and the spouse will be counted. (Re. MS 28035)
9. Assign rights to medical support /third party liability (Re. MS 1350).

28020 Definition of Working 09-15-01

As defined for this category, working means being employed in any ongoing work activity for which income is received and reported to the IRS. Employment must be verifiable by viewing paycheck stubs, tax returns, form 1099, or proof of Quarterly Estimated Taxes for self-employment. The disabled individual must be working at the time of application. If an individual stops working temporarily, and states that he/she intends to return to work, coverage can continue for up to six months. If the individual has not returned to work by the end of the sixth month, a ten-day advance notice will be given on form DCO-700, and the case closed after the tenth day. The caseworker will review the individual's circumstances to determine if he/she is eligible in another Medicaid category, and if so, certify the individual in that category.

28025 Disability Determination 02-01-01

Only individuals with current, on-going, physical or mental disabilities should be considered for Working Disabled.

The individual must be disabled according to the SSI definition of disability. To be eligible, the applicant must have already had disability established through SSI or SSA, or disability must be established through the Medical Review Team.

Individuals who are currently employed, and apply for Medicaid to cover medical bills for a temporary disability due to illness or surgery and plan to return to work after a period of recuperation, are not eligible in this category and should not be referred to MRT. Such applicants should be evaluated for eligibility in other Medicaid categories.

Persons who have received SSI or SSA disability within the last year, and lost entitlement solely due to employment, can automatically be considered disabled at the time of application. However, disability must be re-determined at the first annual re-evaluation. Procedures for verifying disability through SSI/SSA and the Medical Review Team found at MS 3322 through MS 3323.6 should be followed.

A disability determination through MRT for this category will not consider whether an individual is engaged in substantial gainful activity (SGA).

Note: Individuals may still be receiving SSA based on disability and have earnings over the SGA. SSA allows a 9-month extension of benefits when earnings exceed the SGA. If SSA benefits cause the individual to be income ineligible for Working Disabled, the County Office should inform the applicant to reapply after SSA benefits stop.

28030 Income Determination 09-15-01

Income eligibility will be determined in a two-step process. Only the income of the disabled individual will be used to determine eligibility. Any income of the spouse or children will be disregarded.

Step 1 –

First determine the amount of unearned income for the individual. Only individuals with unearned income under the SSI/SPA will be eligible in this category. SSI exclusions and disregards (Re: MS 3348-3348.1) will be allowed. Total all unearned income for the individual and subtract the $20.00 general exclusion. If the resulting amount is under the SSI/SPA for an individual, proceed to the second step. If the resulting amount is over the SSI/SPA, deny the application.

Step 2 –

Determine the individual's gross monthly earnings. If there was no unearned income, subtract the $20.00 general exclusion from the earned income. Deduct $65.00 plus ½ of the remaining gross earnings. Add the net unearned income, if any, and remaining net earnings to determine countable income. Compare the total to 250% of the federal poverty level for the individual's family size. If the income falls below the 250% level, the individual is eligible. (Refer to the FPL chart at Appendix F for current amounts.)

Family, in this category, is defined as the applicant, his/her spouse, and the minor children, natural or adoptive, of either spouse. To be included in the family unit, children must be under 18 years of age and reside in the home of the disabled individual.

28035 Resources 02-01-01

Countable resources are determined according to LTC guidelines (Re. MS 3330-3333) with certain exceptions. A second car can be disregarded as a resource if it is used by the spouse to maintain employment. There will be no penalty imposed for the transfer of resources; and all funds held in retirement accounts, including private retirement accounts such as IRAs and other individual accounts and employer-sponsored retirement plans such as 401(K) plans, Keogh Plans and employer pension plans will be disregarded as resources.

Only the resources of the individuals and the spouse will be counted. Although children are included in the standard, their resources are not counted. Countable resources are compared to twice the MNRL for the family size.

An "approved account" can be established by the disabled individual and be used to enhance independence and increase employment opportunities. Funds in the approved account, up to an established maximum, are disregarded in the resource calculation (Re. MS 28040).

Working Disabled Resource Limits

Household Size	Resource Limit
1 (Individual)	$4000
2 (Individual & Spouse)	$6000
3	$6200
4	$6400
5	$6600
6	$6800

NOTE: Add $200 for each additional family member.

28040 Approved Account **02-01-01**

An approved account may be used to save for any expense that will enhance an individual's independence and/or increase employment opportunities. The account must be kept separate from all non-exempt accounts such as regular savings and checking accounts. Up to $10,000.00 of an approved account can be disregarded as a countable resource. Interest generated on an approved account will not be counted as income. If the interest generated causes the approved account to exceed $10,000.00, or the approved account otherwise exceeds $10,000.00, the amount in excess of $10,000.00 will be counted toward the resource limit for the individual's family size.

If an individual declares a checking account, savings account, or cash at the time of application, he/she will be given the opportunity to designate all or part of the funds as an approved account. If the individual designates only a portion of the funds as an approved account, he/she should be given a written notice via the DCO-700 with instructions to separate the account and provide verification of the new account within 10 days. If the funds designated for the approved account are not deposited into a separate account, they will be counted as a resource.

Some approved expenditures follow:

Educational Expenses-Expenditures for training to enhance employment and independent living skills which include tuition, fees, books and other related expenses.

Work–Related Expenses-Expenditures for job accommodations, equipment, service animals, computer software and hardware, business capital, tools and other related expenses.

Home Purchase/Modification-Costs of acquiring, constructing, modifying or reconstructing a residence to meet the needs of the disabled individual.

Transportation-Cost of acquiring, modifying, maintaining or repairing a motor vehicle to be used by the disabled individual, or an immediate family member, on his/her behalf. The cost of insurance for the vehicle is also included.

Medical Expenses-Medically related expenditures, including dental bills, not covered by Medicaid or other insurance, and Medicaid co-pays.

Assistive Technology and Related Services-Expenditures for assistive technology devices, which include any item, piece of equipment, product system, or assistive technology service that is used to increase, maintain, or improve functional capabilities of individuals with disabilities. The term "assistive technology service" means any service that directly assists an individual with a disability in the selection, acquisition, or use of an assistive technology device. These services include:

A. The evaluation of the assistive technology needs of an individual with a disability, including a functional evaluation of the impact of providing the appropriate assistive technology and services to the individual in his/her customary environment.
B. Services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices, and services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices.
C. Coordination and use of necessary therapies, interventions, or services associated with education and rehabilitation plans and programs.
D. Training or technical assistance for the disabled individual, or where appropriate, the family members, guardian or authorized representative of the individual.

When establishing the approved account, the individual must state in writing the intended purpose of the account. The signed statement must include the projected cost of the item(s) or services for which they are saving. If at any time the individual has no intended use for the money in the account, or the intended use is for items that do not meet the definition of an approved item, the account will become a countable resource.

At each re-evaluation, the County will review the approved account history for the past year. The individual must provide receipts for any expenditure from the account. If the individual has accessed the account and used the money for a non-approved reason, the amount withdrawn will be considered unearned income in the month withdrawn. A new signed statement of intended use must be provided at each re-evaluation.

In the case of qualified emergencies, funds may be withdrawn and used for living expenses if there is a hardship on the family caused by such instances as extended illness, loss of employment, natural disasters, or similar events beyond the control of the individual.

28045 Cost Sharing 02-01-01

Recipients of Medicaid for the Working Disabled with gross income under 100 percent of the Federal Poverty Level for their family size (Re. FPL chart at Appendix F for current amounts) will be subject to the usual Medicaid co-pays. Recipients with gross income equal to or greater than 100 percent of the FPL will be assessed co-payments at the point of service for medical visits and prescription drugs according to the following schedule:

1. Physician's visits - $10.00;
2. Prescription drugs - $10.00 for generic, $15.00 for brand name;
3. Inpatient Hospital – 25% of the first day's Medicaid per diem rate;
4. Orthotic appliances, prosthetic devices, durable medical equipment & augmentative communication devices – 10% of the Medicaid maximum allowable reimbursement rate;
5. Occupational, physical and speech therapy, & private duty nursing - $10.00 per visit, with a cap of $10.00 per day.

After certification, any increases in income that cause the individual to exceed 100% of the FPL, will not be processed until the next reevaluation. If the individual reports a decrease in income that puts him under the 100% FPL, his income will be adjusted when reported to reflect the lower co-payment amounts. Any increase in co-payments determined at reevaluation will require a 10-day advance notice. A DCO-700 will be sent and the changes keyed after the notice is up.

28050 Approval of Applications 02-01-01

Applications for the Working Disabled will be made on form DCO-777, "Application for Assistance, Long Term Care and Other AABD Categories", by the individual requesting assistance, or his/her authorized representative, at the DHS County Office located in the individual's county of residence.

In instances where disability is already established, the County Office will have 45 days to dispose of the application by approval, denial, or withdrawal. When eligibility must be established by MRT, 90 days will be allowed for processing.

28055 Denials and Withdrawals 02-01-01

If an applicant does not meet all of the eligibility requirements for Working Disabled, the application will be denied.

The caseworker will record the pertinent information stating the reason for denial; complete the denial data on the application form and notify the applicant of the denial by DCO-700 or DCO-55 (system generated notice).

If an individual wishes to withdraw the application, the caseworker should obtain a signed statement from the applicant stating that he/she wishes to withdraw the application. The procedures for denying an application will then be followed.

28060 Effective Date of Eligibility 02-01-01

Eligibility will begin on the date of application unless retroactive coverage is needed. If retroactive coverage is needed, and eligibility is established for a retroactive period, eligibility can begin up to 3 months prior to the date of application; but in no case can coverage be authorized before February 1, 2001.

28065 Re-evaluations 02-01-01

Medicaid eligibility for the Working Disabled will be re-evaluated annually by the County Office. The application form and all other forms required at initial application will be completed. If the individual has an approved account, the County will review the account history for the past year, and a new statement of intended purpose for the account will be obtained.

An MRT disability re-determination may or may not be necessary at re-evaluation. If a re-examination by MRT is necessary, it will be indicated on the DCO-109. Individuals that did not require an MRT decision initially due to loss of SSA or SSI in the previous year will require an MRT determination at the first re-evaluation.

28070 Changes and Closures 02-01-01

When a change occurs that affects eligibility, or an increase in the cost sharing (Re: 28045), a ten day advance notice of action will be given unless advance notice is not required (Re. MS 3633). Case closure will be effective the date the notice expires.